GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

Medicaid Program

RECEIPIENT INFORMATION

RECIPIENT NAME: LAST FIRST INITIAL SUFFIX

RECIPIENT MEDICAID CASE NO.

PATIENT'S ACKNOWLEDGEMENT OF PRIOR RECEIPT OF HYSTERECTOMY INFORMATION

Section 1— Recipient's Statement

I have been told and I under that this hysterectomy (operation to remove my womb uterus) will cause/has caused me to be permanently sterile (unable to bear children).

_____.. _____
Signature of Medicaid Recipient Date

OR

_____ _____
Signature of Recipient Date

STATEMENT OF MEDICAL NECESSITY

Section II – Physician's Statement

The above mentioned hysterectomy will be/has been performed for medical necessity, not for sterilization, hygiene purposes or mental retardation.

Check one of the below **if applicable**. – (Recipient's signature not required if number 1 or 2 is applicable.)

1. Recipient was sterile prior to hysterectomy. The recipient was sterile because _____

_____

_____

2. Emergency Hysterectomy: (Attach a copy of the discharge summary and operative record to validate the emergency hysterectomy.)

_____
Physician's Name (Please print)

_____ _____
Physician's Signature Date

DMA 276 (Rev. 4/03)